DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 12, 2012 through April 25, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 sample totaled 49 residents.	F 000	ENTERED MAY 09 2012 BY: _____ **The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.** **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following Plan of Correction. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.**	6/4/12
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Quast — TITLE: Administrator — (X6) DATE: 5/18/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review of facility resident fund accounts, corporate accounting methodology and interview and correspondence with corporate accounting staff, it was determined that the facility corporation failed to recognize and resolve a reconciliation discrepancy. Findings include: As of 3/30/2012, a summation of the bank balance of $53,802.78, trial balance of $36,829.56, outstanding checks of $16,863.44, and unawarded interest of $4.79 resulted in a discrepancy of $105.00 in the resident trust fund account.	F 159	F159 1. Resident fund accounts are being managed by Resident Fund Management System (RFMS), from National Data Care ensuring a full and complete separate accounting of each resident's personal funds with reconciliations. Audit was completed after discrepancy was brought to their attention and funds reconciled so they matched. 2. All residents with fund accounts deposited with the facility have the potential to be effected. Resident funds are being managed by RFMS from National Data Care. 3. RFMS will monitor account balances to insure balances match and recognize and reconcile all discrepancies. An audit was completed of resident fund accounts at the corporate level to insure all discrepancies are recognized and resolved.	6/4/12
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH	F 160		

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F 160	Continued From page 2 Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policies, it was determined that the facility failed to ensure personal funds were conveyed within 30 days of the death of a resident. Findings include: Review of R40's personal fund account indicated, as of 4/20/2012, there was $322.94 remaining in the account. R40 had expired on 2/14/2012. Review of R40's medical record revealed that this resident had a responsible party, and the facility had contact information for this person. However, the facility did not convey R40's funds to the responsible party. Review of the facility policy regarding Closing Accounts, revealed the account will be closed and a check shall be issued within 30 days of discharge when a resident is discharged from the facility. Interview on 4/20/12 with E25 (Business Office Manager) confirmed that R40's personal funds were not conveyed within 30 days after death according to facility policy.	F 160	determine if anyone has discharged or expired. The BOM will notify the Global Healthcare representative when a resident has been identified and the account will be closed. A check will be sent that week. 4. On a monthly basis, an audit will be completed to review any discharges that month to assure the accounts have been closed and the monies refunded. Results of this audit will be brought forward to month QA.	6/4/12
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	F 205	F- 205 1. R-129 responsible party was given a copy of the bed hold policy notification. 2. All residents who are discharged to the hospital have the potential to be affected by the deficient practice.	

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F 205	Continued From page 3 Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide one resident (R129) or their responsible party with written bed hold information upon transfer to the hospital. Findings include: R129 is a long term Medicaid resident residing in the facility since 11/23/10. Review of the clinical record revealed that the first notice of the duration of the bed hold policy specifying a 7 day bed hold was signed by R129's responsible party on 11/25/10. R129 was transferred to the hospital on 2/26/12.	F 205	3. Bed hold policy was reviewed by Administration and a new Bed hold notification form was added. Bed hold policy was updated to reflect this. Admission Coordinator will be responsible for providing the Bed hold notification to the resident/responsible party. Admissions, Social Services, and Licensed Nurses were in-serviced on 4/25/12 by Staff Development Coordinator on the use of the Bed hold Notification form. All discharges to the hospital will be reviewed in morning meeting to ensure a bed hold notification has been generated. Admissions will keep copies of all bed hold notifications sent out for 3 months.	6/4/12

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F 205	Continued From page 4 Interview with E9 (Admissions Director) on 4/24/12, confirmed that the resident and/or responsible party did not receive a second written notice of the bed hold policy upon transfer to the hospital.	F 205	4. An audit comparing hospital transfers with bed hold notifications will be conducted monthly times 3 months to ensure compliance with this requirement. Results will be brought through the monthly QA process for review and potential need for further training and/or monitoring.	6/4/12
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

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F 225	Continued From page 5 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and review of facility policies and procedures and other documentation, it was determined that the facility failed to ensure that all alleged violations that had the potential for abuse and/or neglect for two (R108 and R25) out of 49 sampled residents were immediately reported to the administrator of the facility and the State Agency (Division of Long Term Care Residents Protection). Additionally, the facility failed to ensure that these allegations were thoroughly investigated. Findings include: 1. Review of a resident/family grievance report, dated 4/11/12 revealed that R108 alleged that on the day shift on 4/11/12, she had been laying in a bowel movement for over an hour. She stated that she was ringing her call bell and when no one answered, she started yelling for help. E108 stated that when the CNA (Certified Nurse's Aide) came to clean her up, "They had me naked in the lift with the window open and they only washed my back." Interview on 4/25/12 with E11 (Quality Assurance) confirmed that an incident report was never completed. Interview on 4/25/12 with E3 (Assistant Director of Nursing) confirmed that the alleged incident of resident abuse/neglect was	F 225	F 225 1. R 108 and R 25 were interviewed regarding the allegation of neglect of 4/11/12 and an incident report was completed on this complaint. This was reported to the state on 4/24/12. State investigators reviewed these 2 incidents and reported to administration that the allegations were unsubstantiated. 2. All residents have the potential to be affected by this deficient practice. 3. A review was completed of all concerns reported in the last 3 months to ensure there was no other unreported allegations of abuse/neglect. Procedure for investigating allegations of abuse/neglect was	6/4/12

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F 225	Continued From page 6 never reported to the State Agency. Review of facility documentation revealed that the facility failed to complete an incident report and failed to ensure that this alleged violation, which had the potential of abuse/neglect was immediately reported to the administrator of the facility and to the State survey and certification agency. 2. Review of a resident/family grievance report, dated 4/7/12, revealed that R25 alleged that on the evening shift of 4/6/12 he had no CNA (Certified Nurse's Aide) until 8:00 PM. He wrote that his call light was on for 2-3 hours and no one changed him. Additionally, he wrote that when a nurse did enter his room she told him to stop yelling because she was on the phone and then pulled his curtain. The report also stated that after calling the nurse's station from his phone, he was hung up on. Review of facility documentation revealed that the incident was assigned to E8 (RN/Unit Manager) for investigation on 4/10/12, 4 days after the occurrence. The facility failed to complete an incident report and failed to ensure that this alleged violation, which had the potential for abuse and/or neglect was immediately reported to the administrator of the facility and to the State survey and certification agency. Review of the investigative notes and staff statements revealed that there were only two statements obtained. One statement was from E6 (nurse who entered room) and one from E7 (CNA assigned for R25's care on the evening of 4/6/12). The facility failed to interview any other	F 225	reviewed and updated as necessary. Licensed nurses and Dept managers were in-serviced by SDC on 5/11/12 on the requirements for reporting and investigating allegations of abuse and/or neglect. All concerns will be reviewed in morning meeting with the Interdisciplinary team to see if they meet the requirements of reporting and to review the investigation progress until the issue is resolved. Investigations of alleged abuse/neglect will be completed by the Director of Social Services and/or the DON. The Administrator will review completed investigation to ensure investigation is complete and reported as required under	6/4/12

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F 225	Continued From page 7 staff who were on duty at the time to obtain any additional information. Thus the facility failed to conduct a thorough investigation. During an interview with E1 (Administrator) and E2 (Director of Nursing) on 4/24/12 they acknowledged the findings.	F 225	State guidelines. 4. All allegations of abuse will be logged by Social Services to insure all components of the review were completed in a timely manner. Results of this tracking will be reviewed in the monthly QA meeting to monitor compliance with this.	6/4/12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to promote care for two (R156 and R33) out of 49 Stage II sampled residents in a manner and an environment that maintains or enhances each residents dignity and respect in full recognition of his individually. Findings include: 1. Observation on 4/12/12 of lunch in the Seaside dining room revealed that R156 had an adaptive cup for drinking. The cup was made out of plastic and the outside surface of the cup was peeling and flaking off. 2. Observation on 4/12/12 of lunch in the Seaside dining room revealed that R33 had an adaptive cup for drinking. The cup was made out of plastic and the outside surface of the cup was peeling and flaking off.	F 241	F 241 1. R 156 and R 33 were both given new adaptive cups to facilitate their ability to drink during meals. 2. All residents with adaptive equipment have the potential to be affected by this deficient practice. 3. All adaptive equipment was inspected by the food service manager and replaced as necessary.	

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F 241	Continued From page 8 On 4/12/12 these findings were confirmed with E12 (Food Service Director).	F 241	The food service manager will regularly inspect all dishes and adaptive equipment to insure they are in good working order. Dietary staff was in-serviced by the Food Service manager on 5/18/12 regarding replacing worn or defective dishes, cups, or adaptive equipment. 4. Food Service manager will report the replacement of adaptive equipment and dishes monthly through the QA process to ensure monitoring of these items is being completed.	6/4/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R226) out of 49 sampled residents received care and services in the facility with reasonable accommodations of individual need and preference. Findings include: R226 had diagnoses which included acute respiratory failure, gout, hypertension, diabetes mellitus type 2, obesity and coronary atherosclerosis. According to R226's Minimum Data Set (MDS) assessment, dated 4/17/12 this resident's BIMS (Brief Interview for Mental Status) score was 14 out of 15 and she needed extensive assistance of 2 persons for bed mobility, transfer, toilet use, personal hygiene and was totally dependent for washing and showering. During an interview with R226 on 4/16/12 at 10:40 AM, she stated that she had no shower	F 246	F 246 1. R 226 was interviewed by the Unit Manager regarding her preference for showering and hair	

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F 246	Continued From page 9 since she was admitted on 4/10/12 (a week). She had wanted her hair washed and the staff used a wet towel and wiped her head. This was not acceptable to her. She stated that she preferred a shower so that her hair would be washed. In an interview with E45 (CNA) on 4/19/12 at 10:15 AM, she stated that R226's shower/hair wash days were on Mondays and Thursdays on the 3-11 PM shift. According to the CNAs' Bath Type Detail Report", R226 was provided bed baths and partial baths from 4/10/12 through 4/16/12 and no shower. There was no documented reason in the report as to why a shower was not provided in accordance with the resident's scheduled shower plan. At an interview with R226 on 4/19/12 at 9:40 AM, she stated she had her first hair wash done the other day that is 4/17/12 (after a week). Review revealed that it was noted in the CNA tracker sheet as tub bath. Interview with E46 (RN) on 4/19/2012 at 10:30 AM confirmed this finding.	F 246	washing. R 226 care-plan and Kardex were updated to reflect this. 2. All residents have the potential to be affected by this deficient practice. 3. Resident records were reviewed to ensure choices of shower and/or bed bath were noted in the resident record. CNA's were in-serviced by the SDC by 5/18/12 regarding the importance of respecting the resident's choices regarding care. Residents will be interviewed periodically by management staff to ensure choices and preferences are being honored. 4. Results of resident interviews will be reviewed monthly through the QA process to ensure	6/4/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide	F 253		

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F 246	Continued From page 9 since she was admitted on 4/10/12 (a week). She had wanted her hair washed and the staff used a wet towel and wiped her head. This was not acceptable to her. She stated that she preferred a shower so that her hair would be washed. In an interview with E45 (CNA) on 4/19/12 at 10:15 AM, she stated that R226's shower/hair wash days were on Mondays and Thursdays on the 3-11 PM shift. According to the CNAs' Bath Type Detail Report", R226 was provided bed baths and partial baths from 4/10/12 through 4/16/12 and no shower. There was no documented reason in the report as to why a shower was not provided in accordance with the resident's scheduled shower plan. At an interview with R226 on 4/19/12 at 9:40 AM, she stated she had her first hair wash done the other day that is 4/17/12 (after a week). Review revealed that it was noted in the CNA tracker sheet as tub bath. Interview with E46 (RN) on 4/19/2012 at 10:30 AM confirmed this finding.	F 246	compliance with resident's right to reasonable accommodations of preferences and needs. F 253 1. The bathroom ceiling vents in rooms 200, 205, and 207 were cleaned immediately. The unpainted walls in 303 and 342 were painted and the bathroom door was repaired in 342. The bathroom tiles and wall in 309 were repaired and replaced. 2. Although no residents were identified in this deficiency all residents have the potential to be affected by this deficient practice. 3. Walking rounds were completed by the Administrator and ~~DON to identify~~ any housekeeping/maintenance concerns to	6/4/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide	F 253		

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F 253	Continued From page 10 maintenance services necessary to maintain an orderly interior. Findings include: During the environmental tours on 4/20/12 with E26 (Environmental Services Director) and E27 (Maintenance Director) the following concerns were observed: 1. Dusty bathroom ceiling vents were observed in resident rooms 200, 205, and 207. Interviews with E26 (Environmental Services Director) confirmed these findings. 2. Unpainted, repaired walls were observed in resident rooms 303 and 342. Additionally, the bathroom door in resident room 342 was in disrepair. Interviews with E27 (Maintenance Director) confirmed these findings. 3. Observations of the bathroom in resident room 309 on 4/19/12 at 10:00 AM revealed that the floor tiles had separated and that the bathroom wall was in disrepair. Interviews with E27 (Maintenance Director) confirmed these findings.	F 253	maintain a sanitary and comfortable environment. All areas identified were addressed by housekeeping and maintenance. IDT were in-serviced by the SDC by 5/18/12. Daily Environmental Rounds will be completed by Dept managers and results brought forward to the morning meeting. 4. Results of the Daily Rounds will be reviewed by the Administrator and areas of concern will be monitored for completion.	6/4/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 11 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop a comprehensive care plan for two (R147 and R129) out of 49 Stage II sampled residents and that included measurable objectives and timetables to meet the resident ' s medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Findings include: 1. R147 had diagnoses which include pneumonia, Renal Failure, Hypertension, Peripheral Vascular Disease, Hypothyroidism, Dementia with Behavioral Disturbances, Anxiety State, Alzheimer's Disease, Vascular Dementia with Delusions, and Urinary Frequency. Review of the 3/5/12 quarterly Minimum Data Set (MDS) assessment, dated 3/5/12 revealed R147 was coded for having physical and verbal behavior symptoms directed toward others on 4-6 days of the 7 day review period. Review of R147's CNA (Certified Nurse's Aide) behavior flow sheets for 2/12, 3/12 and 4/12	F 279	F 279 1. R 147's care plans were updated on 4/19/12. R 149's care plans were updated on 5/10/12. 2. All residents on psychotropic medications have the potential to be affected by the deficient practice. All residents on psychotropic medications will have psychotropic care plans reviewed and revised by 5/21/12. 3. Psychotropic medication changes to be brought forward to clinical meeting. Care plans to be reviewed/revised with	6/4/12

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F 279	Continued From page 12 revealed that staff were documenting on each shift the following behaviors: verbally abusive, resists care and socially inappropriate. Review of a physician's order, dated 4/16/12 revealed an order for Zyprexa (antipsychotic) 2.5 mg everyday at bedtime for delusions. Review of R147's care plan, dated 3/21/12 revealed that the facility did not address the problem, goals and interventions of these specific behaviors and the use of the antipsychotic medication. These findings were confirmed with E44 (nurse) on 4/24/12. 2. R149 was admitted to the facility with diagnoses including dementia, anxiety, depression and schizophrenia. The 14 day MDS (Minimum Data Set) assessment, dated 11/17/11 triggered the care areas of Behavior symptoms and psychotropic drug use and was checked off to be addressed in the care plan. R149's quarterly 3/5/12 MDS assessment documented that signs and symptoms of delirium (C1300) and wandering (E 0900) still persisted. Review of R149's records contained a psychiatric consultation, dated 4/9/12 which documented "Assessment: dementia Alzheimer's type with delusion and depression. Plan: continue celexa (antidepressant) 20 mg(milligrams) for depression, depakote (miscellaneous treatment) 125mg at night and 250mg in morning for mood, aricept 10 mg HS (@ bedtime) and namenda 10mg twice a day for dementia, seroquel (antipsychotic) 25mg twice a day for mood and	F 279	changes in psychotropic medications and quarterly as needed. 4. An audit will be conducted weekly X 4 weeks by the DON/Designee to ensure compliance with care plans. The results of this audit will be reported to the QA committee. The QA committee will determine the need for further audits.	6/4/12

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F 279	Continued From page 13 valium (benzodiazepine) 2mg three times a day for anxiety. The patient is stable. No recommendation at this time." Review of R149's care plan (start date 3/5/12) revealed three focuses "receives 9 or more medications and is at risk for adverse drug reaction; elopement risk related to dementia and socially inappropriate behavior but none addressed the use of psychotropic drugs and their side effects or the use of the behavior flow sheet. The focus on elopement risk related to dementia and socially inappropriate behavior also failed to include this drug usage. Although the facility was monitoring the behaviors of delusions, anxiety and withdrawn on a behavior monitoring flow sheet which listed some of R149's medications (seroquel, valium and citalopram), there was no care plan for its use nor side effects information on the form. During an interview with E20 (charge nurse) on 4/24/12 at 10:45 AM, she acknowledged lack of a care plan for psychotropic drug use which included monitoring side effects. The facility failed to develop a care plan that addressed the resident's use of psychotropic medications and the monitoring of the side effects. Findings reviewed on 4/25/12 at 4:40 PM with E1 (NHA), E2 (DON) and E3 (ADON).	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	F 280 1. R 43 positioning device was re-applied correctly. R 43's care plan reviewed and revised on 5/11/12. R 22's care plan reviewed and revised on 5/11/12. 2. All residents with the use of positioning devises and that are being tube fed have the potential to be affected by the deficient practice. Residents with positioning devices and tube feedings were identified and their care plans will be reviewed and revised as needed by 5/21/12.	6/4/12

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F 280	Continued From page 14 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that the care plan was reviewed and revised for two (R43 and R22) out of 49 Stage II sampled residents. Findings include: 1. Observation of R43 on 4/20/12 while she was sitting in her w/c in the hall across from the nurse's station revealed, that she had a positioning device on her wheelchair under her arm on the left side. A physical therapy treatment record, dated 3/1/12 stated that the patient appears to be leaning to the right while seated in her wheelchair. Positioning devices were added to her wheelchair to keep her upright.	F 280	3. Residents receiving positioning devices initiated by therapy will be brought forward to morning meeting and care plans revised accordingly. All residents receiving Tube feeding will have care plans reviewed and revised quarterly and as needed. 4. Audits will be conducted by the MDS coordinator for residents with positioning devices weekly x 4 weeks to ensure care plans are updated with positioning device changes. Results of the care plan audits will be reported to the QA committee to determine further recommendations and/or follow-up to enhance and improve process.	6/4/12

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F 280	Continued From page 15 Interview on 4/20/12 with E18 (Physical Therapist) confirmed that he was the one who initiated these positioning devices for R43. The devices included a wider arm rest for the right side of the wheelchair and a positioning pad that was to go under R43's right arm and attached to the wheelchair. Review of R43's care plan, dated 3/26/12 revealed that it was not revised to include use of these positioning devices. Close refer to F312 2. R22's care plan initiated on 8/12/2011 stated, "Resident was totally dependent of staff for all Activities of Daily Living (ADLs) self performance, deficit r/t stroke, limited ROM, limited mobility musculoskeletal impairment, hemiplegia and limited mobility". The care plan goal was "The resident will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene" The interventions were focused on Toilet use, transfer, use of call bell, skin inspection, bathing, bed mobility and dressing but left out personal hygiene care that would include oral/dental hygiene care. Another care plan initiated on 8/12/11 stated, "Tube [gastrostomy tube] required to assist resident in maintaining or improving nutritional status characterized by weight loss related to aspiration, swallowing impairment, paralysis".	F 280		

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F 280	Continued From page 16 The interventions were focused on checking residual and positioning of the tube, care of the tube and feeding by tube. However the interventions failed to include oral/dental hygiene care.	F 280	F 309 1. R 52's fluid restriction monitoring form was initiated on 4/19/12. There were no adverse effects related to the deficient practice. R 43 positioning device was re-applied correctly. R 43 had no adverse effects R/T deficient practice. 2. All residents on a Fluid restriction have the potential to be affected by the deficient practice. All residents with positioning devices have the potential to be affected by the deficient practice. 3. During monthly review, the UM will cross-reference all residents on a fluid restriction to ensure fluid restriction monitoring forms are carried over. Residents receiving positioning devices initiated by therapy	6/4/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (R52 and R43) out of 49 sampled residents. Findings include: 1. Review of R52's medical record revealed diagnoses of Hypertension, Urinary Tract Infection, Renal Failure, Diabetes type 2, Hyperlipidemia, Osteoarthritis, Dementia, Behavior Disturbance, Depressive Disorder, Chronic Pain, Reflux, and Hypertonicity of	F 309		

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F 309	Continued From page 17 Bladder. Review of R52's fluid restriction notification/allocation form, dated 12/3/11 revealed that R52 is on a 1000cc per day fluid restriction with allocations divided between nursing and dietary. R52's Minimum Data Set (MDS) assessment, dated 3/26/12 states under Section C- nutrition assessment for diet of no added salt, non concentrated sweets with 1000cc fluid restriction. Section L - assessment/goals/approaches states," hydration status appears good. Is on fluid restriction which she looks to be fairly compliant with." Review of R52's care plan, initiated on 3/26/12 revealed that there were focus areas addressing acute renal failure - fluid restriction, edema/excess fluid volume related to cardiac disease with interventions which consisted of monitoring intake and compliance to 1000cc fluid restriction and dietary and/or fluid restrictions per doctor's order. Review of R52's Fluid Restriction Tracking Form for 2/12 and 3/12 revealed that nursing staff on all three shifts were inconsistent with the documentation of the 1000cc fluid restriction. For the month of 4/12, it was discovered that the nursing staff did not have a fluid restriction form for R52 until it was brought to their attention by the surveyor on 4/19/12 and consequentially failed to have a sytem in place for the month of April to monitor and evaluate all of R52's fluids. . During an interview on 4/19/12 with E14 (nurse),	F 309	will be brought forward to morning meeting and care plans revised accordingly. Primary Care CNA, Nurse, and Unit Manager will be trained on the new positioning devices. Therapy manager or designee will in-service nurses and CNA's once a month to ensure all staff is knowledgeable regarding proper placement of positioning devices. 4. An audit will be conducted once a week x 4 weeks on all residents on a fluid restriction. Results of the audit will be brought forward to QA committed to determine need for further audits/follow up. An audit will be conducted once a week x 4 weeks by the DOR to ensure residents have	6/4/12

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F 309	Continued From page 18 she stated " fluid restriction forms are kept on the Medication Administration Record (MAR)". E14 confirmed that R52 did not have this form on her 4/12 MAR. On 4/19/12, during an interview with E15 (nurse), she stated "any resident on fluid restriction should have a fluid restriction form in their MAR". E15 showed this surveyor several residents who were on fluid restriction and the form was present in their MAR. 2. R43's medical record revealed diagnoses of Urinary Tract Infection, Hypertension, Renal Failure, Hyperlipidemia, Alzheimer's Disease, Anxiety, Chronic Obstructive Pulmonary Disease and Dysphagia. A Physical Therapy Treatment Record, dated 3/1/12 stated " Patient appears to be leaning to the right while seated on her wheelchair. Positioning devices were added to her wheelchair to keep her upright. " Review of R43's Physical Therapy discharge summary, dated 3/6/12 revealed discharge recommendations: Cognitive-communicative strategies, positioning/pressure relieving techniques and passive range of motion exercises in order to maintain integrity of the joints and preserve current level of function. Observation of R43 on 4/19/12 while in the hall seated in her wheelchair revealed that she had a positioning pad laying under her left arm and across her stomach. It was noted by this surveyor that the positioning pad was not applied correctly to the wheelchair. When E8 (nurse), E14 (nurse)	F 309	positioning devices applied properly. Results will be brought to QA committed to determine the need for further audits/follow up.	6/4/12

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F 309	Continued From page 19 and E21 (CNA) were asked to apply the device correctly, they did not know how. They proceeded to take the resident back to her room to apply the device. A second observation of R43 on 4/19/12 by the surveyor and E16 (Occupational Therapy Assistant) when she was in her room after E8, E14 and E21 re-applied the device revealed that the positioning pad still was not applied correctly. This was confirmed by E16. Interview on 4/20/12 with E18 (Physical Therapist) revealed that he was the therapist that had initiated the positioning devices for R43, which consisted of a wider arm rest for the right side of the wheelchair and the pad positioning device for the right side. During an interview on 4/20/12 with E17 (Physical Therapy Director), he stated that when a resident receives a new order for a device, that the primary caregivers are instructed on how to use them and that nursing is responsible for training the other staff members. Observations on 4/23/12 and 4/24/12 of R43 revealed that she continued to be seated in her wheelchair with the positioning pad on the left instead of the right side as indicated by E18.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 1. R 22 received oral care immediately. 2. All dependent residents have the potential to be affected by the deficient practice. E 48 educated on proper technique regarding morning care and oral hygiene. 3. All C.N.A's to be in-serviced by SDC regarding consistent oral hygiene by 5/18/12.	6/4/12

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F 312	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R22) out of 49 sampled residents, who was unable to carry out activities of daily living received the necessary care to maintain good oral hygiene. Findings include: R22 had diagnoses of cerebral vascular accident (CVA) with hemiplegia and dysphagia, hypertension and diabetes mellitus. According to R22's quarterly Minimum Data Set (MDS) assessment, dated 2/16/2012, R22 had a (BIMS) Brief Interview for Mental Status score of 12 out of 15, speech unclear but was able to express and was usually understood. R22 was totally dependent on staff for all activities of daily living. R22 was only receiving nutrients via tube feeding. According to this resident's "MDS Kardex Report"/CNA's care plan, R22 had "Oral problems" and needed daily oral care. However, R22's CNA's daily care flow sheet did not address the daily need for R22's oral care. There was no documentation that this resident was receiving daily oral care. Observations on 4/16/12 at 11:36 AM and on 4/20/12 at 9:30 AM, revealed R22's mouth contained debris/teeth not brushed, lower teeth with film not clean, lips with dry debris, (whitish flake and white crusting on the outer aspect); tongue thick and coated with whitish debris.	F 312	4. An audit will be completed by UM/Designee of 10% of dependent residents weekly x 4 weeks to ensure oral hygiene is completed during routine care. Results to be brought forward to the QA committee to determine the need for further audits/follow up.	6/4/12

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F 312	Continued From page 21 On 4/20/12 at 9:30 AM, R22 was observed, with this resident's permission, being provided a bed bath by E48 (CNA) and E49 (CNA). Oral hygiene was not part of their plan of care. E48 (CNA) explained that it was done earlier in the morning. However, R22 denied this and stated (pointing to E48) that E48 (CNA) said she (R22) did not need it. E48 asked the resident if she wanted to have her mouth cleaned? R22 stated yes. E49 assisted this resident with her oral hygiene by manual cleaning her teeth and mouth with a swab soaked with a mouth wash cleaning agent. Review of the CNA's daily care flow sheet did not address R22's daily need for oral care and did not contain documentation that R22's oral hygiene was scheduled to be done daily. The facility failed to assist R22 to maintain consistent oral hygiene daily and as needed.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to ensure that one (R129) out of 49 sampled	F 318	F 318 1. R 129 has not had an adverse effect related to the deficient practice. 2. Residents requiring PROM have the potential to be affected by the deficient practice. E 21 is no longer employed by the facility. 3. C.N.A.'s will be in-serviced on proper technique for ROM by the SDC and/or Physical Therapist by 5/18/12. Upon hire and annually CNA's	6/4/12

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F 318	Continued From page 22 residents received appropriate treatment to maintain range of motion. Findings include: The facility's policy Rehabilitative Nursing Care stated:(paragraph 4) 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes but is not limited to: f. Assisting residents with their routine range of motion exercises. The facility also maintained a ROM policy that specifically describes how to perform the exercise from the head to the toes. R129 had diagnoses which included intracranial hemorrhage, convulsions, encephalopathy, malignant neoplasm of laryngeal cartilages, aphasia and tracheostomy. R129 was admitted with contractures of all four limbs. Measurements were documented on the facility's ROM (range of motion) contracture form on 12/31/10. R129's ROM care plan initiated on 9/11/11 (target date 5/9/12) and entitled "actual contractures" noted: Goals- 1) maintain or improve joint mobility 3) remain free from complications of impaired ROM through next review. Interventions- 3) report and document any declines in ROM ability, 4) refer to therapy as needed, 6) turn and reposition q (every) 2 hours and PRN (as needed, 7) reposition for comfort as needed at end of ROM session, 9) cue as needed to complete task, 10) provide only the amount of assistance necessary to ensure task is successfully completed. Record review revealed that R129 had a physician's order, dated 10/18/11 to wear a splint to the left elbow for four hours daily, which was	F 318	will be checked for Care skills by a licensed nurse. Additional training will be provided as indicated. 4. Audit will be conducted by the MDS coordinator of 10% of residents that are receiving ROM weekly x4 weeks to ensure proper technique is being used. Results of this audit to be brought forward to QA committee to determine further recommendations and/or follow-up to enhance and improve process.	6/4/12

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F 318	Continued From page 23 documented very frequently as refused (resident able to verbalize "no") in the electronic charting system used by the CNAs. Another order, dated 10/18/11 noted "resident to perform PROM (passive range of motion) to all ext (extremities) x 10 mins. TID (three times daily)", which the CNAs documented electronically as having been completed. On 4/19/12 at approximately 1:50 PM after observing R129 at varied times on the 7-3 shift, E 21 (CNA) was asked to review R129's care orders and how she documented them. Upon review of the PROM order, E21 stated that when R129 is checked for incontinence care and is repositioned and turned every 2 hours; that such action is considered ROM. Interview confirmed actual ROM of extremities was not performed. E21 and E24 (recently hired CNA) both stated that their skills training was taught by CNAs only; no nurse reviewed skills with them. Findings were reviewed with E23 of Staff Development along with the Nursing skills checklist of the last three newly hired CNAs. Skills such as toileting, mechanical lift operation, ROM and documentation are listed. The checklist must be completed and returned to her within 5 working days of floor orientation. No licensed nurse verifies if the CNAs training is accurate. E23 revealed that she does not choose the trainers, it is handled by scheduling. The facility policies and the 4/19/12 findings were reviewed with E22 (Scheduler/CNA) with E23 present on 4/24/12 at 11:00 AM. E22 confirmed the training process but stated that only experienced CNAs are selected and that they are	F 318		

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F 318	Continued From page 24 not provided with a preceptor training class. E22 stated that ROM training was recently conducted by the head of physical therapy (PT) to nursing staff. Interview with E17 (PT Director) at 11:30 AM on 4/24/12 confirmed a ROM inservice was conducted on 2/22/12 for all three nursing shifts. Review of sign in sheets revealed E22 attended the inservice. Findings were reviewed with E1 (NHA), E2 (DON), E3, (ADON) on 4/25/12 at 4:40 PM.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide an environment that was free from accident hazards as was possible for three (R115, R156 and R33) out of 49 sampled residents. Additionally, the facility failed to identify that residents could exit out of a nursing unit into the parking area without detection and that the elopement safety alarm was not functioning on another unit door that exits outside the building. Findings include: 1. Observation on 4/23/12 revealed that the	F 323	F323 1. R115 no longer resides in facility. R156- armrest was replaced on 4/23/12. R338- armrest to w/c was replaced on 4/23/12. Seaside door was secured with sliding bolt immediately. Aspen unit door fixed on 4/23/12. 2. All residents with a w/c have the potential to be affected by the defective practice. All residents with a wander guard have the potential to be affected by the deficient practice- w/c & doors were fixed immediately.	6/4/12

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F 323	Continued From page 25 armrest coverings of R115's wheelchair were in disrepair presenting a potential injury to the resident. Staff interviews confirmed these findings. 2. Observation on 4/23/12 revealed that the armrest coverings of R156's wheelchair were in disrepair presenting a potential injury to the resident. Staff interviews confirmed these findings. 3. Observation on 4/23/12 revealed that the armrest coverings of R33's wheelchair were in disrepair presenting a potential injury to the resident. Staff interviews confirmed these findings. 4. On 4/12/12 at 12:30 PM, E11 (QA nurse) was at the Seaside unit patio door (used for smokers) to assist with testing the wanderguard alarm used to deter resident elopement. The patio exit had two doors. The right door had a push bar. E11 used the coded key pad to unlock the doors in order for the surveyor, with an activated wanderguard alarm, to exit outside to the smoking area. The alarm did not sound when the surveyor exited to the patio. The door closed and was reopened for the surveyor to return into the unit and the alarm did not sound. This sequence was repeated again with the right door with the wanderguard in varied positions but the alarm still did not sound an alert. E11 contacted E27 (director of maintenance) to come to the unit. E27 arrived with a tester. E11 stated that the surveyor's wanderguard had alarmed correctly on 3 other exit doors. E27 unlocked the doors with	F 323	3. W/c armrests that need to be replaced identified during ambassador rounds on a daily basis and notification to maintenance through the regger system will occur once identified. Seaside door with secure lock to prevent elopements on 5/14/12. Aspen door refurbished with new internal system as well as Mag lock for security. Staff will be in-serviced by Maintenance Director on the need to notify his dept immediately of any doors that present with a potential safety issue by 5/18/12. 4. Maintenance will complete an audit of 10% of w/c q wk x4 weeks to ensure armrests are in good repair. Maintenance to monitor doors weekly to ensure	6/4/12

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F 323	Continued From page 26 the key pad and exited the left door (which had no push bar) and the tester activated the alarm. When the surveyor exited the left door and re-entered, the alarm was activated. When E27 exited and re-entered the right door, the alarm did not sound. E27 attempted 3 more times with the tester in various positions but there was no alarm. E3 (ADON) arrived at 12:46 PM to assess the situation. E3 confirmed that the alarm system was not operating correctly on the right door and ordered E27 to secure the right door from use and to consult the alarm company. The door was secured with a sliding bolt within one hour. On 4/23/12 at 8:50 AM, E27 observed the Aspen unit exit door with the surveyor. E27's log book revealed all doors are tested daily to ensure the wanderguard system is active and no problems were reported about the Aspen door. The Aspen doors are two sets of sliding doors with a small foyer between the unit and the outside parking area which leads to the main road. The outside sliding door has a sensor that automatically opens to exit or enter. A key pad system must be used to enter and exit the unit door. Two staff members were observed using this process. While observing a crack on the wooden strip along the side of the inside unit door, the surveyor was able to put fingers along the side and pull the door open to exit into the foyer. E27 completely closed the door while the surveyor was in the foyer. The surveyor was able to pull the door open again with fingers (along the side) and enter without use of keypad system. E27 revealed that the door was not to open in this manner without use of the code key system. He contacted an outside source for repair and testing.	F 323	proper function of secure exits. Results of this audit to be brought forward to QA committee to determine further recommendations and/or follow-up to enhance and improve process.	6/4/12

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F 323	Continued From page 27 Findings were reviewed with E3 (ADON) on 4/23/12 at 9:05 AM.	F 323	F 328 1. R 19's oxygen concentrator filter was cleaned immediately. R 29's oxygen concentrator filter was cleaned immediately. 2. All residents requiring oxygen therapy have the potential to be affected by the deficient practice. Nurse responsible for cleaning the filter was in-serviced by Staff Development on proper technique on 5/18/12. 3. Nursing staff to be in serviced by the SDC coordinator on cleaning O2 filters weekly by 5/18/12. 4. Unit Managers to audit oxygen concentrator filters weekly x 4 weeks for cleanliness. Results to be brought forward to QA committee to determine further recommendations and/or follow-up.	6/4/12
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that respiratory equipment (concentrator filters) for two (R192 and R29) out of 40 Stage II sampled residents were maintained in a clean manner. Findings include: Review of facility policy entitled, " Protocols for Concentrators and Nebulizer's " stated that filters for the (oxygen) concentrators must be checked and cleaned weekly and then put back on the machine. The night shift (11-7) is responsible for cleaning the filters. 1. Observation on 4/20/12 of the oxygen concentrator in use by R192 revealed that the filter was dusty. Staff interview confirmed the findings.	F 328		

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F 328	Continued From page 28 2. Observation on 4/20/12 of the oxygen concentrator in use by R29 revealed that the filter was dusty. Staff interview confirmed these findings.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure it was free of medication errors of five percent or greater. Three medication errors were identified during the medication pass for one resident (R105) that included Senna (stool softener) and the antiulcer medications Carafate and Prilosec. Findings include: R105 was observed receiving medications on 4/20/12 at 9:35 AM by E43 (LPN) during the medication (med) pass. Findings were reviewed and confirmed with E43 and E11 (Quality Assurance nurse). a) R105 received Senna 8.6 mg 2 tablets (tabs) by mouth during the med pass. A physician order, dated 8/26/11, was for Senna 8.6 mg 2 tabs (17.2 mg) by mouth BID (twice a day). When R105 returned to the facility from an ER visit on 2/14/12, the order was entered by facility staff into their computerized system incorrectly as Senna 17.2 mg 2 tabs (34.4 mg) BID. Review of R105's	F 332	F 332 1. R 105 still resides in the facility. No adverse reactions R/T deficient practice. 2. All residents have the potential to be affected by the deficient practice. Immediate clarification of orders was obtained by physician on 4/23/12. 3. Nursing Staff to be in serviced by SD on formulary interchange and procedure for changing orders upon notification from pharmacy by 5/24/12. Staff Development to in-service nursing staff on proper dosing of medication upon transcription into PCC	6/4/12

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F 332	Continued From page 29 medication administration record (MAR) revealed that facility staff signed that they administered Senna 17.2 mg 2 tabs (34.4 mg) BID since 2/14/12, yet E43 administered 8.6 mg 2 tabs (17.2 mg) during the med pass. It could not be determined what doses of Senna were given since 2/14/12 as this was a stock med, except as noted. E11 notified the physician on 4/24/12 and the order for 17.2 mg 2 tabs BID was discontinued and changed to 8.6 mg 2 tabs BID. b) R105 had a physician order, dated 4/9/12, for Carafate 1 G (gram) to be given by mouth before meals (in accordance with manufacturer's specifications). E43 incorrectly administered Carafate at 9:35 AM on 4/20/12 (after meal) although the medication was timed in the MAR to be given at 7 AM-11:30 AM- 5 PM. c) R105 had a physician order, dated 2/13/12, for Protonix (antiulcer med) 40 mg by mouth BID (twice a day). The pharmacy automatically substituted Prilosec 40 mg which the physician approved. Facility staff incorrectly entered the order into their computerized system as Protonix 40 mg by mouth daily (instead of BID) on 2/14/12. Although Prilosec and Protonix are antiulcers meds, they are not the same medication. On 4/9/12, a physician ordered the Carafate and Protonix to be administered together before meals. During the med pass, E43 administered Prilosec 40 mg by mouth, not Protonix as ordered. Record review revealed there was no order for Prilosec. The facility failed to discontinue the Prilosec order on 2/13/12 and obtain an updated order for Protonix.	F 332	by 5/24/12. SD to in-service nurses to provide medications that is to be given prior to breakfast at 0600 med pass by 5/24/12. 4. UM's to audit all formulary interchanges weekly x 4 weeks to identify proper administration of medication. UM's to audit 10% of MARs to ensure right dosage of medication weekly x 4 weeks. Results of this audit to be brought forward to monthly QA process for review and potential need for further training and/or monitoring.	6/4/12

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F 332	Continued From page 30 Review of the MAR revealed that facility nurses incorrectly signed that they administered Prilosec daily since 2/13/12 when they were actually giving Protonix. Additionally, the medication should have been given twice daily, not daily and it was signed off as being administered at 8 AM (should have been before meals with Carafate as per the 4/9/12 order). On 4/23/12, E11 contacted the physician and received an order to discontinue the Protonix 40 mg daily. Prilosec 40 mg every 12 hours was ordered by the physician on 4/24/12 and it was retimed to be administered at 6 AM.	F 332	F371 1. The concentration of quaternary ammonium compound was adjusted to Manufacturer's directions immediately. The steam table pan lids were corrected immediately. The pans of squash and chicken were covered immediately. The walk in refrigerator gasket will be repaired or replaced by 6/1/12. The food spills in the ice cream freezer were cleaned up immediately. The inside thermometer to the freezer was placed in a location that is easy to find immediately. 2. Although no residents were identified in this deficiency all residents have the potential to be affected by this deficient practice.	6/4/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/12/12 with E12 (Dietary Director), it was determined that the facility failed to prepare and serve food under sanitary conditions. Findings include: 1. Two buckets with quaternary ammonium compound (QAC) sanitizer were tested at a	F 371		

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F 371	Continued From page 31 concentration of 150 and 50 MG/L, respectively. Manufacturer's use directions recommended a concentration of 200 MG/L. 2. Two steam table pan lids stored on the ready-to-use rack contained a pool of water. 3. Pans of squash and chicken by the kitchen exhaust hood were stored uncovered. 4. Walk-in refrigerator door gasket was in disrepair. 5. Food spills were observed on the bottom shelf of the ice cream freezer. Additionally, the inside temperature measuring device was in a location as not to allow easy viewing. Interviews with E12 (Dietary Director) on 4/12/12 confirmed these findings.	F 371	3. Dietary staff to be in-serviced by food service director on manufactures' guidelines for quaternary ammonia concentration sanitizer, storage of items in ready to use rack to be air dried, uncovered food items, cleaning up spills and monitoring the freezer temperature gauge to ensure it is visible. 4. An audit will be conducted daily x 30 days by the food service director/designee for uncovered food, sanitizer at 200ppm, food spills in ice cream freezer, temperature gauge in ice cream freezer and air dried dishes. Results of the audit will be brought forward to QA committed to determine need for further audits/follow up.	6/4/12
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 412		

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F 412	Continued From page 32 determined that the facility failed to provide and/or obtain dental services for one (R106) out of 49 sampled residents. Findings include: R106 was originally admitted to the facility on 6/11/07. Diagnoses included anemia, congestive heart failure, hypertension, diabetes mellitus and cerebral vascular accident (stroke). The 1/12/12 significant change Minimum Data Set (MDS) assessment stated that R106's cognitive skills were moderately impaired and that she had no dental issues. Review of R106's clinical record lacked evidence of any routine dental services since her admission to the facility. Interview with R106's responsible party on 4/13/12 confirmed that R106 had not had any dental services provided since admission to the facility. Observation of R106 on 4/20/12 at 10:15 AM revealed she only had 5-6 of her front lower teeth. When asked, R106 denied any difficulty eating or chewing her food. During a second interview with R106 on 4/24/12, when asked when she had last seen a dentist she stated "a long time ago." Review of facility contracts revealed the facility had a contractural agreement for dental services. During an interview with E5 (MDS Coordinator), she confirmed that R106 had not been provided with any routine dental services since admission to the facility.	F 412	F 412 1. Resident R106 will be seen at Nemours Health Clinic for dental appointment. 2. All residents have the potential to be affected by the deficient practice. 3. The Interdisciplinary team will meet with residents, families and/or responsible parties quarterly to discuss plan of care including dental services if needed. Dental appointments will be scheduled at Nemours or dentist of choice per resident/family /responsible parties consent. 4. An audit will be completed by UM/Designee on each resident for dental health to ensure adequate dental services is being received. Appointments will be scheduled as needed.	6/4/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 33 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	Results of the audit to be brought forward to monthly QA process for review and potential need for further training and/pr monitoring. F441 1. R 226 has not had an adverse effect related to the deficient practice. 2. All residents with a treatment order requiring a dressing change have the potential to be affected by the deficient practice. Employee E 47 was in-serviced on facilities hand washing an infection control practices during dressing changes on 4/26/12. 3. Nursing Staff will be	6/4/12

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F 441	Continued From page 34 Based on a wound dressing change observation, it was determined that the facility failed to ensure staff washed their hands when hand washing is indicated and consistent with accepted professional standard of practice to reduce the spread of infections and prevent cross-contamination. Findings include: Observation of a dressing change to R226's left heel diabetic ulcer and left heel lateral deep tissue injury was performed by E47 (RN) on 4/19/12 at approximately 10:00 AM. The necessary equipment and supplies included Silvadene, hydrogel, 4x4 gauze, roll gauze and normal saline and these were set up on a clean bedside table on top of a clean barrier placed on the table. R226 was made comfortable in bed, the door to the room was closed and the privacy curtain was pulled. E47 washed and dried his hands thoroughly with a clean towel and donned a pair of clean gloves. E47 removed the soiled dressing from around R226's left heel, discarded the soiled dressing in a trash can lined with a plastic bag, then removed and discarded the contaminated gloves into the same trash can. E47 donned a new pair of clean gloves to proceed with the treatment of the left heel ulcers and the left lateral deep tissue injury without handwashing first. He then proceeded to finish the procedure. This finding was discussed with E47 (RN) on 4/19/12 and he confirmed this finding.	F 441	in-serviced on proper hand washing guidelines and infection control policies during dressing changes by the SDC by 5/18/12. 4. Director of Nursing to observe 3 wound/dressing changes for compliance with hand washing and infection control guidelines weekly x4 weeks. Results of these observations to be brought forward to QA to determine further recommendations and/or follow-up to enhance and improve process.	6/4/12
F 465	483.70(h)	F 465		

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F 465 SS=D	Continued From page 35 SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a safe work environment for the dietary staff. Findings include: Observations on 4/12/12 at 9:32 AM during a tour with E12 (Dietary Director) revealed a pool of water by the ice machine. The ice machine drain line was not in alignment with the floor drain resulting in a pool of water of approximately 2 feet in diameter. The pool of water is a potential hazard to the kitchen staff. Findings were acknowledged by E12.	F 465	F 465 1. Pool of water was cleaned up immediately. 2. No resident was affected by the deficient practice. 3. The drain line was repaired immediately by maintenance. Kitchen staff was in-serviced by maintenance director on 5/18/12 regarding the importance of notifying maintenance any potentially unsafe work environment concerns. 4. Maintenance will check drain line twice a week x 4 weeks. Results of observations to be brought forward to QA committee for review to determine further follow-up to enhance and improve process.	6/4/12
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with	F 497		

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F 497	Continued From page 36 cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, it was determined that the facility failed to insure that 13 out of 13 sampled nursing assistants received the mandatory 12 hours of in-service training required per year beginning with the date of hire. Findings include: 1. E29 was hired 10/2/2007. Review of in-service records revealed a shortage of 4 hours of training. 2. E30 was hired 5/17/2005. Review of in-service records revealed a shortage of 6 hours of training. 3. E31 was hired 11/16/2005. Review of in-service records revealed a shortage of 4 hours of training. 4. E32 was hired 4/1/2001. Review of in-service records revealed a shortage of 3 hours. 5. E33 was hired 4/1/2001. Review of in-service records revealed a shortage of 4 hours. 6. E34 was hired 9/2/2003. Review of in-service records revealed a shortage of 9 hours. 7. E35 was hired 3/7/2006. Review of in-service records revealed a shortage of 6 hours. 8. E36 was hired 2/19/2009. Review of in-service	F 497	F 497 1. All 13 employees were notified of their failure to complete mandatory in-service training. 2. Audit was completed by the SDC on all current c.n.a.'s to ensure that mandatory in-service hours are up to date. C.N.A.'s that are out of compliance with mandatory in-service hours will be required to complete by May 18, 2012. 3. SDC will assign mandatory education monthly in-service hours to C.N.A.'s through Upstairs Solutions. 4. Audit will be completed monthly by SDC to determine compliance with mandatory in-service hours for C.N.A's.	6/4/12

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F 497	Continued From page 37 records revealed a shortage of 6 hours. 9. E37 was hired 4/1/2001. Review of in-service records revealed a shortage of 2 hours. 10. E38 was hired 6/26/2007. Review of in-service records revealed a shortage of 8 hours. 11. E39 was hired 10/16/2002. Review of in-service records revealed a shortage of 7 hours. 12. E40 was hired 12/11/2001. Review of in-service records revealed a shortage of 2 hours. 13. E41 was hired 12/31/2002. Review of in-service records revealed a shortage of 3 hours. Lack of in-service hours was confirmed by E42 (Staff Development Nurse).	F 497	Results to be brought forward to QA. QA to analyze data to determine further recommendations and/or follow up to enhance and improve process.	6/4/12

DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

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Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: April 25, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from April 12, 2012 through April 25, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 sample totaled 49 residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	Cross reference F159, F160, F205 F225, F241, F246, F253, F279, F280 F309, F312, F318, F323, F328, F332, F371, F412, F441, F465, F497

Provider's Signature [signature] Title NHA Date 5/18/12

DELAWARE HEALTH
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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report dated 4/25/12, F159, F160, F205, F225, F241, F246, F253, F279, F280, F309, F312, F318, F323, F328, F332, F371, F412, F441, F465 and F497.	
3201.7.0	Plant, Equipment and Physical Environment	
3201.7.5	Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code. Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 4-501.114 (C) (2), 4-903.11 (B) (1), 3-305.11 (A) (1) and (2), 4-501.11 (B), and 4-204.112 (A) of the State of Delaware Food Code. Findings include: 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization – Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under ¶ 4-703.11 (C) shall meet the criteria specified under § 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows:	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(C) A quaternary ammonium compound solution shall: (2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. This requirement was not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #1. Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. Clean Equipment and Utensils shall be stored as specified under ¶ (A) of this section and shall be stored: In a self-draining position that allows air drying. This requirement was not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #2. 3-305.11 Food Storage Except as specified in ¶¶ (B) and (C) of this section, Food Shall be protected from contamination by storing the Food:	Cross reference F371 Cross reference F371

AME OF FACILITY: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: April 25, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	In a clean, dry location. **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #5. **(2) Where it is not exposed to splash, dust, or other contamination.** **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #3. **4-501.11 Good Repair and Proper Adjustment.** **Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.** **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #4. **4-204.112 Temperature Measuring Devices.**	Cross reference F371 Cross reference F371
	Except as specified in ¶ (C) of this section, cold or hot holding	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	equipment used for potentially hazardous food (Time/Temperature Control for Safety Food) shall be designed to include and shall be equipped with at least on integral or permanently affixed temperature measuring device that is located to easy viewing of the device's temperature display. **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/25/12, F371, Example #5.	Cross reference F371